

VOLUNTARY CENTRAL ADOPTION REGISTRY APPLICATION INSTRUCTIONS

Complete the 2-page Voluntary Central Adoption Registration application and mail it and the following items to:

VSU – CAR
DSHS MC2096
P.O. Box 149347
Austin, TX 78714-9347

- _____ A \$30.00 check or money order, payable to: **DSHS**
- _____ Proof of age and identity in the form of a photo ID, i.e., a current driver's license, passport, or State ID, and
- _____ If your name has changed due to marriage, a copy of a legal document that includes your maiden name, i.e., a copy of a birth or marriage certificate.
- _____ If you are a biological sibling, a copy of your birth certificate must be included in order to verify the biological relationship;
- _____ If your name has been legally changed, a certified copy of the court order verifying the name change should accompany the request.

Information for the Adoptee:

If a child-placing agency was involved in your placement, you may be able to request a non-identified/ redacted copy of your adoption record from the adoption agency files. Vital Statistics Unit houses records from many closed child-placing agencies. To review the list of available closed child-placing agency records that we maintain, please visit online at:

<http://www.dshs.state.tx.us/vs/reqproc/adoptagencies.shtm>

If interested in knowing the identity of the court and the cause number of your adoption, please include an additional \$10 fee (total of \$40) and check "yes" to "I have included an additional \$10 (total fee of \$40) to receive the identity of the court of adoption" on page 2, Part 6, of the Voluntary Central Adoption Registry application. The court that granted the adoption requires this information if you wish to petition the court to order the unsealing of your adoption record.

All Applicants: Please note that processing your Registry application may take as long as 45 days. If you have any questions, please contact our office at 1-888-963-7111 x7388 or x6279, send an e-mail to warren.magjarevich@dshs.state.tx.us.



Texas Voluntary Central Adoption Registry REGISTRATION APPLICATION

Department of State Health Services

Part I: REGISTRANT INFORMATION (all applicants complete this section)

NAME – First	Middle	Last	Maiden Name	Suffix
OTHER NAMES USED (including married, aliases, nicknames)				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date	Age	Social Security Number	E-mail address	
Mailing Address		City	State	Zip
Telephone (including Area Code)	Birth City	Birth County	Birth State/Country	
I am: (check all that apply) <input type="checkbox"/> Adoptee <input type="checkbox"/> Birth Mother <input type="checkbox"/> Birth Father <input type="checkbox"/> Birth Sibling				

Part II: INFORMATION TO BE COMPLETED BY ADOPTEE (complete as many items as possible)

How old were you when you were placed in your adoptive home?	County of Adoption	Agency of Adoption	Date of adoption or approximate year
Adoptive Mother's name (including maiden name)	Date of Birth	Her religious affiliation	What city and/or county were your adoptive parents living in when you were placed with them?
Adoptive Father's name	Date of Birth	His religious affiliation	
Was child welfare or child protective services involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, where was the child living when removed from care (city and/or county)?		Year of removal
Name of Birth Mother <input type="checkbox"/> Unknown	Her date of birth and her age at time of your birth		Delivering Doctor's name
Name of Birth Father <input type="checkbox"/> Unknown	His date of birth and his age at time of your birth		Are you aware of any siblings? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete Part IV. <input type="checkbox"/> Unknown

Part III: INFORMATION TO BE COMPLETED BY BIRTH PARENT(S) (complete as much as possible)

If you are registering for more than one child, please complete a separate application for each child.

Birth name of child (First, Middle, Last, Maiden) <input type="checkbox"/> Unknown	Adoptive name of child (First, Middle, Last, Maiden) <input type="checkbox"/> Unknown
Date of birth of child (if unknown, give year and approximate time of year)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Hospital or maternity home	Agency of Adoption
City and/or County of Birth & State	Delivering Doctor's Name
Did the birth mother use an alias at the hospital or maternity home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, state name used.
Birth mother's religious affiliation	
Birth mother's full name (include maiden name and all married names)	Date of birth and age at child's birth
State/city of birth	
Birth father's name and last known address	Date of birth and age at child's birth
State/city of birth	
Was the birth mother married at the time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, please provide husband's name
Was child welfare or child protective services involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, where was the child living when removed from care (city and/or county)?
Year of removal	

Your other children:

Name of child (and any aliases or nicknames)	Maiden name	Date of Birth	Place of Birth City/State	Name of Other Birth Parent and Date of Birth

Part IV: INFORMATION TO BE COMPLETED BY BIRTH-SIBLING (complete as many items as possible)**If there is more than one sibling you are registering for, please duplicate this page, as needed.**

Is the sibling you are looking for a: <input type="checkbox"/> full-sibling OR <input type="checkbox"/> half-sibling	If half-sibling, are you related by: <input type="checkbox"/> mother <input type="checkbox"/> father	What order in the biological mother's family is this child? (example, first of five)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Adoptive name of child (First, Middle, Last, Maiden) <input type="checkbox"/> Unknown		Birth Name of Child <input type="checkbox"/> Unknown	
Date of birth of child	City of Birth	County of Birth	Hospital
Birth mother's name, include (maiden name) and all married names.	Her date of birth and age at time of child's birth	Her city/state of birth	Her religious affiliation
Was an alias used by the birth mother at the hospital or maternity home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, state named used	
Birth father's name	Birth father's date of birth and age	His city/state of birth	
Was the birth mother married at the time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If, yes please provide her husband's name, his date of birth		
Was child welfare or child protective services involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, where was the child living when removed from care (city and/or county)? And with whom?		
If you are a sibling, please provide: Your birth mother's full name including maiden and all married names	<input type="checkbox"/> Unknown	Your birth father's full name	
If you are adopted, your adopted or legal mother's full name, including (maiden) and date of birth	If you are adopted, your adopted or legal father's full name, including date of birth		
Why do you believe you have an adopted biological sibling(s)?			
Names of birth siblings you are not looking for	Maiden Name	Date of Birth	Place of Birth
			Half-Sibling Or Full-Sibling
			<input type="checkbox"/> Full <input type="checkbox"/> Half
			Mother
			Father
			<input type="checkbox"/> Full <input type="checkbox"/> Half
			Mother
			Father
			<input type="checkbox"/> Full <input type="checkbox"/> Half
			Mother
			Father

Part V: COMMENTS SECTION (story of placement, additional information not listed above) **Use separate page if needed.**

Part VI: ALL APPLICANTS COMPLETE THIS SECTIONI am willing to allow my identity to be disclosed to those registrants eligible to learn my identity..... ☐ yes ☐ no

I authorize the administrator of the registry to inspect all vital statistics records, court records, hospital records

And agency records including confidential records. ☐ yes ☐ noI consent to the disclosure of my identity after my death. ☐ yes ☐ no**For adoptees only:** I want to be informed if registry records indicate that a biological sibling has also registered ☐ yes ☐ no**For adoptees only:** I have included an additional \$10 (total fee of \$40) to receive the identity of the court of adoption ☐ yes ☐ no

Your application is good for 99 years unless you state a shorter period of time here.....

I certify that the information contained in this form is true and correct to the best of my knowledge.

X Signature _____

Date _____

Mail application, proof of ID and \$30, payable to DSHS:**VSU – CAR (MC2096), PO Box 149347, Austin TX 78714-9347**